Los Alamos National Laboratory
Occupational Medicine Group (HSR-2)
Wellness Center
Mail Stop P955 ● Phone: 667-7166 ● FAX: 665-6140

PHYSICIAN'S APPROVAL REQUEST FORM

Dear Employee:
At the Los Alamos National Laboratory Wellness Center, your safety is our primary concern. For this reason, we comply with the health and fitness standards of the American College of Sports Medicine.
On the Health History Questionnaire you recently completed, you identified one or more coronary and/or other medical risk factors, which may impact your ability to exercise safely. For this reason, you need to have your private physician complete and return this medical clearance form before you can exercise at the Wellness Center.
We recognize that your fitness program is important to you, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that your exercise experience needs to be as safe as possible.
In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the doctor is aware of your medical history, s/he may be able to complete this form and promptly fax it back to us. In many cases the delay before you begin exercising is only one day. We appreciate your patience and cooperation.

FOR EMPLOYEE

I authorize _____
(Printed name of physician, physician group)

_____ _____
(Address) (Fax)

to complete the form below and provide (by mail or Fax) the completed information to the LANL Wellness Center staff for their use in determining my ability to safely participate in Wellness Center exercise programs.

Printed Employee Name: _____ (D.O.B) _____

Employee Signature: _____ Date: _____

FOR PHYSICIAN USE

To the Physician: Please be aware that the Los Alamos National Laboratory Wellness Center is a minimally supervised facility. Your patient is responsible for adhering to any restrictions you outline for her/him.

Please check one of the following statements.

❒ I concur with my patient's unrestricted participation in a vigorous exercise program. I confirm that this individual is medically stable and an appropriate candidate for exercise training.

❒ I concur with my patient's restricted participation in an exercise program. List restrictions: _____

_____

❒ I do not concur with my patient's participation in an exercise program. (If checked, the individual may not exercise at the Wellness Center.)

Printed Physician Name: _____

Signature: _____ Date: _____

Please return form to: LANL Wellness Center
Mail Stop P955
Los Alamos, NM 87545
Phone: (505) 667-7166 Fax: (505) 665-6140